MONTANA
Department of Public Health & Human Services

Big Sky AMES Conference

ACS
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Friday, August 19, 2011
9 a.m.
Fairmont

Welcome and Thank You

- Denise Juvik
  - denise.juvik@acs-inc.com
  - 406-457-9598

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Topics to be Covered

- Provider Information Resources
- Eligibility Verification and Types
- Prior Authorizations
- Claim Submission
- Remittance Advice
- Adjustments
- Top Denials
- Attachments
- Medicare/TPL

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Provider Information Sources

Where do you look?

Who do you call?

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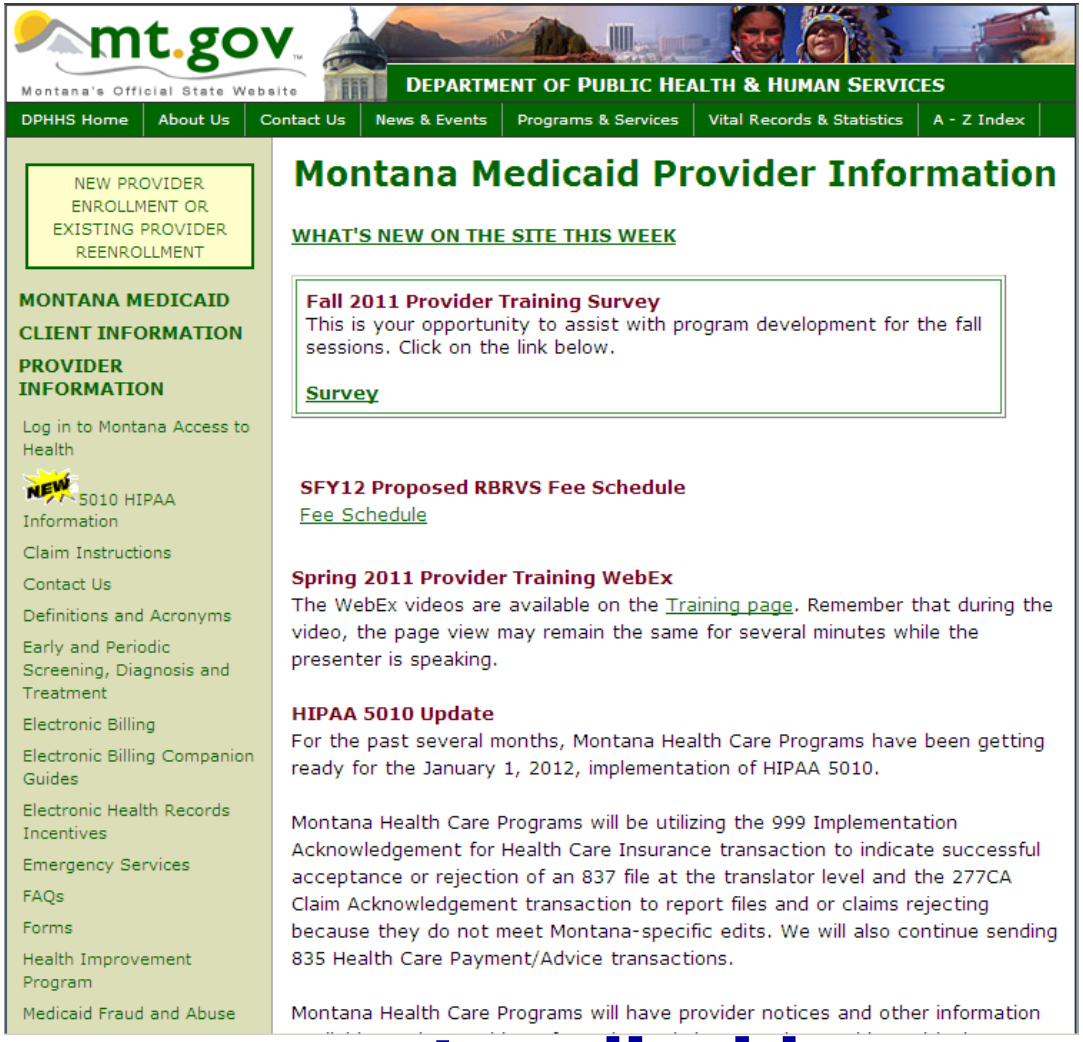
Website Address



www.mtmedicaid.org

Website Information

- Medicaid Rules/Regulations
  - Critical information for ALL providers
- Newsletters
  - *Claim Jumper* and Passport to Health
    - What's new
- Provider Manuals
  - Most current
  - Index in rewritten manuals
  - Searchable

Website Information

- The *General Information for Providers* Manual
  - Basic information about Medicaid
    - Accessible for all provider types
  - Accessible from Provider Resources page
  - www.mtmedicaid.org

NEW PROVIDER ENROLLMENT OR EXISTING PROVIDER REENROLLMENT

MONTANA MEDICAID CLIENT INFORMATION

PROVIDER INFORMATION

Log in to Montana Access to Health

5010 HIPAA Information

Claim Instructions

Contact Us

Definitions and Acronyms

Early and Periodic Screening, Diagnosis and Treatment

Electronic Billing

Electronic Billing Companion Guides

Electronic Health Records Incentives

Select Your Provider Type

Provider types beginning with:
A — C | D — F | G — K | L — O | P — Q | R — Z

Provider Types From A–C

Ambulance (Updated July 18, 2011)
Ambulatory Surgical Center (Updated July 18, 2011)
Audiologist (Updated July 18, 2011)
Chemical Dependency (Updated July 18, 2011)
Chiropractor (QMB) (Updated July 18, 2011)
Clinic (Freestanding Dialysis) (Updated July 18, 2011)
Clinic (Public Health) (Updated July 18, 2011)

Back to Top

Provider Types From D–F

Dental (Dentist, Dental Hygienist) (Updated July 18, 2011)
Denturist (Updated July 18, 2011)
Dialysis Clinic (Freestanding) (Updated July 18, 2011)
Dialysis (Home) (Updated July 18, 2011)
Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) (Updated July 18, 2011)
EPSDT (Updated July 18, 2011)
Eyeglasses (Updated July 18, 2011)
Federally Qualified Health Care Center (FQHC) (Updated July 20, 2011)

Website Information

- Information organized by provider type
  - Provider manuals
  - Fee schedules
  - Notices
  - Replacement pages and other information
  - Payment Schedule

NEW PROVIDER ENROLLMENT OR EXISTING PROVIDER REENROLLMENT

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Emergency Services

Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)

Corrected Contact Numbers

The contact numbers for DMEPOS Prior Authorization in the July *Claim Jumper* were incorrect. The correct numbers are:

Fax: Toll-free local and long-distance 1-877-443-2580

Phone: Local (406) 457-5887

Phone: Toll-free long-distance 1-877-443-4021, Ext. 5887

Provider Manuals (Updated November 26, 2008)
Medicaid Rules/Regulations (Updated May 9, 2006)
Fee Schedules (Updated January 26, 2011)
Notices and Replacement Pages (Updated July 18, 2011)
DMEPOS Workgroup (Updated December 21, 2004)
Other DMEPOS Resources (Updated February 2, 2011)
Remittance Advice Notice
Key Contacts (Updated June 24, 2011)

Provider Manuals

General Information For Providers

Medicaid billing manual with general information for all provider types.
04/2005

Notices and Replacement Pages

07/18/11

Reimbursement Changes for Covered Ancillary Services Provided to Youth in a Psychiatric Residential Treatment Facility (PRTF) and Additional Ancillary Services Are Covered

06/27/11

HIPAA 5010/OCR Qualifier Changes Effective January 1, 2012

06/24/11

Prior Authorization for Rental of Electric Hospital Beds and Bone Growth Stimulators

04/12/11

Request: Claims Submission, Date of Payment by June 30, 2011

10/05/10

Changes to NCCI Edits

07/28/10

Provider Record Update Procedures **Effective Immediately**

06/23/10

Cost Sharing Exemption under ARRA

06/22/10

Electronic Health Records Link

06/14/2010

DMEPOS Manual Replacement Pages - Covered Services

02/09/10

Contact ACS

Provider Relations

Phone: 800-624-3958

Fax: 406-442-4402

Email:

- Ask Provider Relations on the web portal
- mtprhelpdesk@acs-inc.com

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Eligibility Verification

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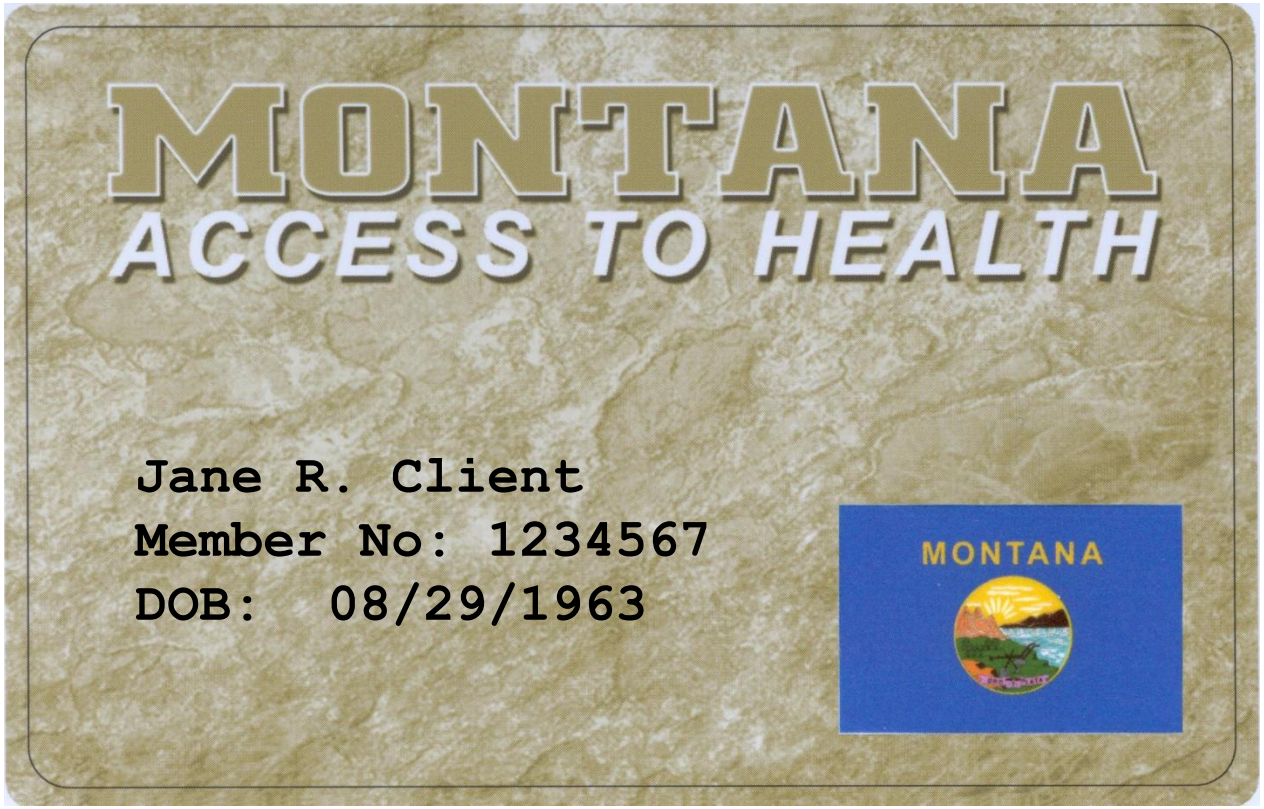
Montana Access to Health Hard Card



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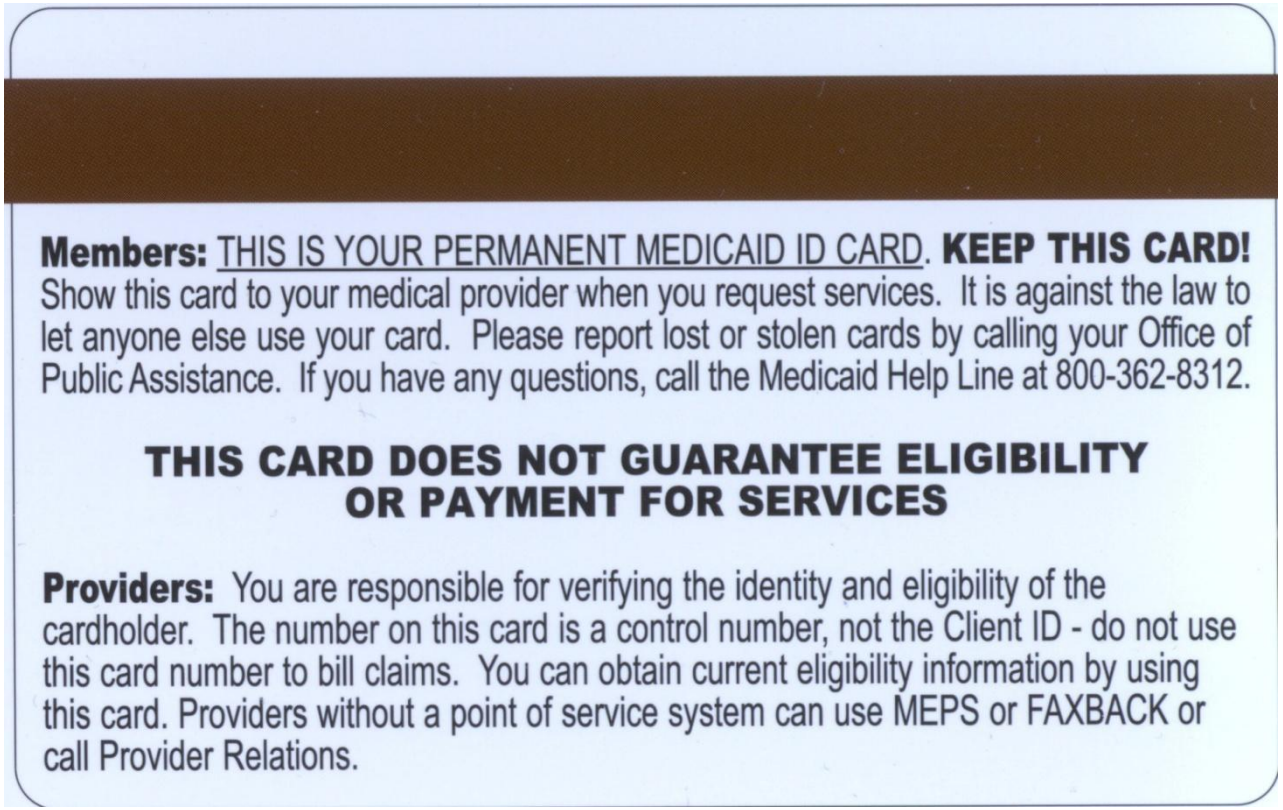
Montana Access to Health Hard Card



Members: THIS IS YOUR PERMANENT MEDICAID ID CARD. **KEEP THIS CARD!** Show this card to your medical provider when you request services. It is against the law to let anyone else use your card. Please report lost or stolen cards by calling your Office of Public Assistance. If you have any questions, call the Medicaid Help Line at 800-362-8312.

THIS CARD DOES NOT GUARANTEE ELIGIBILITY OR PAYMENT FOR SERVICES

Providers: You are responsible for verifying the identity and eligibility of the cardholder. The number on this card is a control number, not the Client ID - do not use this card number to bill claims. You can obtain current eligibility information by using this card. Providers without a point of service system can use MEPS or FAXBACK or call Provider Relations.

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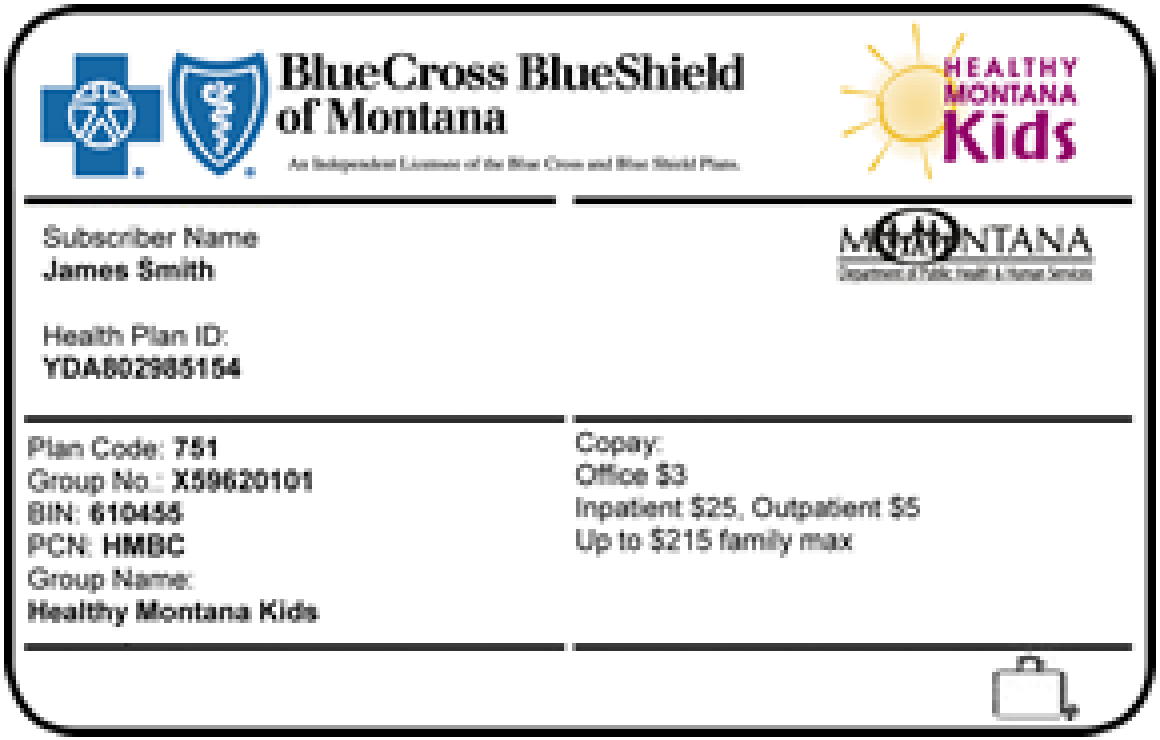
HMK – Healthy Montana Kids



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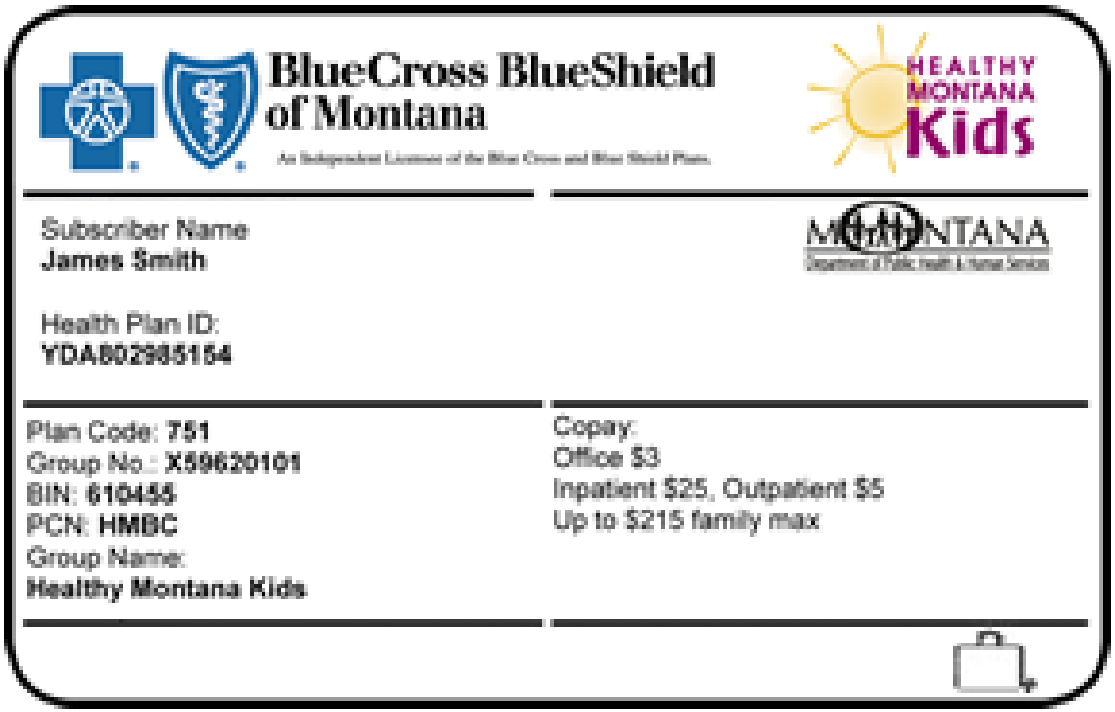
HMK – Healthy Montana Kids



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Eligibility Inquiry Response

Client Demographic Information

Client Original ID:	0000000000	NPI or Provider ID:	0000000000
Client Current ID:		Date of Service:	
Client Member ID:	0000000	Valid Request Indicator:	
Name:	Jim Smith	Reject Reason Code:	
Address:		Follow-up Action Code:	
City:	BUTTE	Date of Death:	
County Code:	47	Trace Number:	2010253181451381T
State:	MT		
Zip Code:	597010000		
Date of Birth:	06/27/1993		
Gender Code:	M: Male		

Eligibility Spans

About HMK/HMKPlus

Service Type Code	Insurance Type Code	Payer Name	Plan Coverage Description	Eligibility Effective Date	Eligibility End Date
30: Health Benefit Plan Coverage	OT: Other	HMK/CHIP	HMK/CHIP Basic Plan	02/01/2001	09/30/2010

Information Source Data

Organization/Last Name:	Medicaid
Identification Code Qualifier:	PI: Payor Identification
Contact Name:	ACS Provider Services
Primary Identifier:	77039
Communication Number:	8006243958

Healthy Montana Kids*Plus*

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Eligibility Inquiry Response

Client Demographic Information

Client Original ID:	0000000000	NPI or Provider ID:	0000000000
Client Current ID:	000000000	Date of Service:	
Client Member ID:		Valid Request Indicator:	
Name:	John Smith	Reject Reason Code:	
Address:	109 SOUTH 1ST STREET	Follow-up Action Code:	
City:	City	Date of Death:	
County Code:		Trace Number:	2010253175708221T
State:			
Zip Code:			
Date of Birth:			
Gender Code:	M: Male		

Eligibility Spans

About HMK/HMKPlus

Service Type Code	Insurance Type Code	Payer Name	Plan Coverage Description	Eligibility Effective Date	Eligibility End Date
30: Health Benefit Plan Coverage	MC: Medicaid	Medicaid/HMKPlus	Full Coverage	06/01/2010	09/30/2010

Managed Care Information

Plan Coverage Description	Plan/PCP Name	Plan/PCP Phone Number	Begin Date	End Date
PASSPORT Provider	LAUREL MEDICAL CENTER	4066286311	08/01/2010	09/30/2010

Eligibility – What You'll See

- Full vs. Basic
- CHIP / HMK (Healthy Montana Kids)
- SLMB, QMB, QI

Eligibility Verification

- Montana Access to Health (MATH) Web Portal
- Automated Voice Response System (AVRS)
- FaxBack
- Provider Relations

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Montana Access to Health Web Portal

- www.mtmedicaid.org
- Created by ACS in conjunction with DPHHS
- Medicaid related information

Montana Access to Health Web Portal

- Active providers
- Appropriate forms available from the website: www.mtmedicaid.org
- Secure website

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FaxBack Facts

- 1-800-714-0075
- Response within minutes
- Paper verification

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Automated Voice Response System Facts

- 1-800-714-0060
- Verbal verification
- Press 3 for eligibility information
- Access one client at a time
  - Multiple clients within phone call
- Free to providers

Eligibility Tips

- Client Control Number on hard card
- Client Medicaid ID number confidential
- Verify at each visit

Eligibility Tips

- If a client does not have eligibility:
  - Private pay arrangements prior to service
- If client believes they have eligibility for the date of service:
  - Contact local Office of Public Assistance prior to service

Eligibility Tips

- If you believe a client may meet Medicaid qualifications:
  - Have client contact local Office of Public Assistance
- If a client is retroactively eligible:
  - Claims past timely filing must include verification of retro eligibility
  - Provider's choice

PRTF

- PRTF
- Must bill direct

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QMB, SLMB AND QI

Medicare Savings Program

What Is the Medicare Savings Program?

- Limited Medicaid benefits are available to pay for out-of-pocket Medicare cost-sharing expenses
  - QMB: Qualified Medicare Beneficiaries
  - SLMB: Specified Low-Income Medicare Beneficiaries
  - QI: Qualifying Individuals

What Are Dual Eligibles?

- Dual eligibles are individuals who are entitled to Medicare Part A and/or Part B and are eligible for some form of Medicaid benefits.

The following chart describes the various categories of individuals known as Medicaid dual eligibles.

Type of Medicaid Benefit				
Dual Eligible Category	**Part A Premium**	**Part B Premium**	**Medicare cost-sharing**	**Full Medicaid Benefits**
Medicaid Only	**No**	**No**	**No**	***Yes***
QMB	**Yes**	**Yes**	**Yes**	***No***
QMB Plus	**Yes**	**Yes**	**Yes**	***Yes***
SLMB	**No**	**Yes**	**No**	***No***
SLMB Plus	**No**	**Yes**	**No**	***Yes***
QI	**No**	**Yes**	**No**	***No***

What Is QMB?

Qualified Medicare Beneficiaries

- QMB client are clients for whom Medicaid pays the Medicare premiums and Medicaid share using lower-of pricing methodology for services covered by Medicare

- QMB clients may or may not also be eligible for Medicaid benefits

How Does a QMB "Only" Claim Process?

- If there is a Medicare payment, coinsurance and/or deductible amount on the line, Medicaid will pay using lower of pricing methodology.

- If there is no Medicare payment, coinsurance or deductible amount on the line or if Medicare pays more than the Medicaid allowed amount, Medicaid will pay at zero.

What Shows on RA if Denied?

- Reason Code: 96
  - Non covered charge/s
- Remark Code: N192
  - Patient Medicare/Qualified Medicare Beneficiary

*Provider can bill client for remainder if claim denies

QMB/Medicaid Claims

- Crossover claims come from GHI
- If submit paper claim must have Medicare EOB
- Pays the lower of pricing on crossover claims.
- If the service is not covered by Medicare but is covered by Medicaid, Medicaid will pay the Medicaid allowed amount.

What Is SLMB?

- Specified Low-Income Medicare Beneficiary
- Medicare premiums only
- Claim will deny
  - Montana Medicaid does not have a payment responsibility for clients with SLMB

What Shows on RA if Denied?

- Reason Code: 96
  - Non covered charge/s
- Remark Code: N30
  - Patient ineligible for this service

SLMB/Medicaid Claims

- Crossover claims come from GHI
- If submit paper claim must have Medicare EOB
- Pays the lower of pricing on crossover claims
- If the service is not covered by Medicare Medicaid will pay the Medicaid allowed if the service is covered by Medicaid.

What Is QI?

- Qualifying Individual
- Medicare premiums only
- Claim will deny
  - Montana Medicaid does not have a payment responsibility for clients with QI

What Shows on RA if Denied?

- Reason Code: 96
  - Non covered charge/s
- Remark Code: N30
  - Patient ineligible for this service

Questions?

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Prior Authorization

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Fee Schedule Indicator

Proc	Mod	Description	Effective	Method	Fee	PA
E0935	RR	PASSIVE MOTION EXERCISE DEVICE	1/1/2009	MEDICARE	$20.29	Y

- Procedure codes that require prior authorization
- Check on fee schedule to see if procedure requires a PA, indicated by Y
- Contact approver prior to providing service

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Prior Authorization Tips

- Check eligibility prior to obtaining a PA
- Verify prior authorization by referring to PA notice
- Correction Responsibilities lie with the Provider
- PA number must appear on the claim form or electronic transmission

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Durable Medical Equipment

Mountain-Pacific Quality Health
1-800-292-7114

- Prior authorizations for amounts over $1000.00
- Additional services require PA

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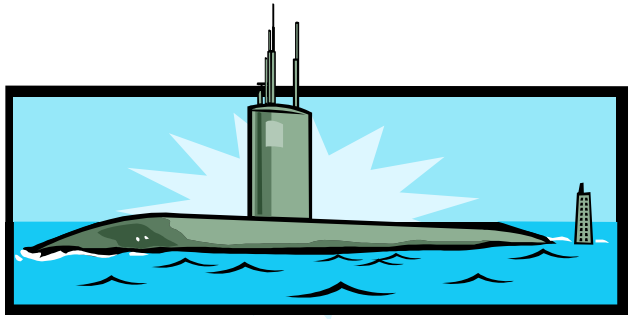
Claim Submission



Electronic Submissions

- To submit claims
  - WINASAP 2003
  - Clearinghouse
  - Billing agent
  - Direct submission
  - Web portal

Clean claims can be processed in two days, depending on day of submission

Electronic Submission Benefits

- Quicker provider payment
- Denied claims can be corrected and resubmitted quickly
- Added accuracy and security
- Cost savings

Paper Claims

- Paper claims mailed to ACS are imaged, data perfected and adjudicated
  - Claims are processed via the Optical Character Recognition program (OCR)
  - Claim forms are available through print shops or may be available on website

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Remittance Advice

BTMC8000-R001
AS OF 02/28/2008

MONTANA DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES
HELENA, MT 59604

REMITTANCE ADVICE FOR MEDICAID/CHIP/MHSP

DR. BEVERELY HILLBILLY
555 STEVENS ST
STEVENSVILLE MT, 59555

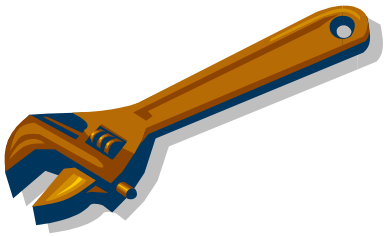
VENDOR # 12345678987 REMIT ADVICE # 555555 EFT/CHK # 5555555 DATE 03/03/2008 PAGE 2
NPI #: 123454321 TAXONOMY: 123454321X

RECIP ID	NAME	SERVICE FROM	DATES TO	UNIT OF SVC	PROCEDURE REVENUE NDC	TOTAL CHARGES	ALLOWED	CO-PAY	REASON & REMARK CODES
PAID CLAIMS - MISCELLANEOUS CLAIM									
123454321	RABBIT, ROGER A	02112008	02112008	3.000	H0036	82.50	47.70		
ICN 55505600253001555 PATIENT NUMBER=155555-VLBHEL1CSC									
TEAM NUMBER 01									
		02122008	02122008	3.000	H0036	82.50	47.70		
		02132008	02132008	7.000	H0036	192.50	111.30		
		02152008	02152008	3.000	H0036	82.50	47.70		
		CLAIM TOTAL*******				440.00	254.40		
123454321	RABBIT, ROGER A	02192008	02192008	3.000	H0036	82.50	47.70		
ICN 55505600253001555 PATIENT NUMBER=155555-VLBHEL1CSC									
TEAM NUMBER 01									
		02202008	02202008	4.000	H0036	110.00	63.60		
		02212008	02212008	10.000	H0036	275.00	159.00		
		02222008	02222008	1.000	H0036	27.50	15.90		
		CLAIM TOTAL*******				495.00	286.20		

Remittance Advice Tips

- Grouped by status
- Do not resubmit a claim in PENDED status
- Work all denial reasons before resubmitting
- Do not post payments listed under Credit Balance
- Always contact Provider Relations if you have questions

Adjustments



Adjustment Types

- Only paid claims!
- Adjustment
  - Correction to a paid claim
- Credit
  - Reversal of a paid claim

Adjustment Types

- Mass Adjustment
  - Mass adjustments are requested for specific populations of claims
  - Reprocess large numbers of similar claims.
  - System generated

- Gross Adjustment
  - Financial transaction not associated with individual claims
  - May be a credit or debit

Adjustment Tips

- Individual Adjustment Form
- Include a copy of the Remittance Advice
- Will not be accepted by telephone
- Only paid claims can be adjusted
- One adjustment form per claim
- Electronic vs. Paper

Updated 03/2011

Montana Health Care Programs

Medicaid • Mental Health Services Plan • Healthy Montana Kids
Individual Adjustment Request

Instructions:
This form is for providers to correct a claim which has been **paid** at an incorrect amount or was **paid** with incorrect information. Complete all the fields in Section A with information about the paid claim from your statement. Complete **only** the items in Section B which represent the incorrect information that needs changing. For help with this form, refer to the *Remittance Advices and Adjustments* chapter in your program manual or the *General Information for Providers* manual, or call (800) 624-3958 (Montana and out-of-state providers) or (406) 442-1837 (Helena).

A. Complete all fields using the remittance advice (RA) for information.

1. Provider Name & Address

Name

Street or P.O. Box

City State ZIP

2. Client Name

3. Internal Control Number (ICN)

4. NPI/API

5. Client ID Number

6. Date of Payment

7. Amount of Payment $

B. Complete only the items which need to be corrected.

	Date of Service or Line Number	Information on Statement	Corrected Information
1. Units of Service			
2. Procedure Code/NDC/Revenue Code			
3. Dates of Service (DOS)			
4. Billed Amount			
5. Personal Resource (Nursing Facility)			
6. Insurance Credit Amount			
7. Net (Billed – TPL or Medicare paid)			
8. Other/Remarks (Be specific.)			

Signature: _____ Date: _____

When the form is complete, attach a copy of the RA and a copy of the corrected claim.

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Mail to: ACS
P.O. Box 8000
Helena, MT 59604

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Adjustment Tips

- Adjustments and credits are processed as replacement claims
- Credits and adjustments must be received within 12 months of the date of service
- To send a refund check
  - Must be made out to DPHHS
  - Mailed to ACS, with the words "History Only" at the top of the Adjustment Request Form

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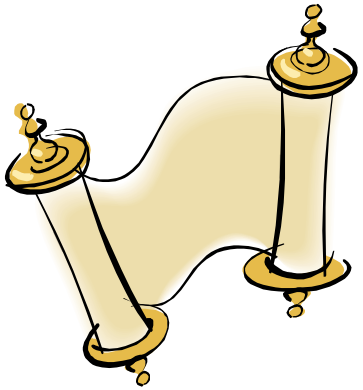
Top Denials

What you can expect, and how you can resolve them.



Medicare

- Medicare EOB and information on the claim do not match.
- Medicare denied requesting more information
- Claim is not on the Medicare EOB
- Medicare Reason and Remark codes are not present

Prior Authorization

- PA missing
  - No PA information was entered on the claim form
- PA invalid
  - Wrong PA entered for DOS
  - PA number does not match
  - Billed units or dollars exceeds approved
  - PA is used

TPL Denials

- Client has TPL
  - TPL not indicated on the claim
  - TPL amount not present on the claim
  - Claim information and EOB do not match
  - TPL denial does not contain reason and remark codes

- Claim indicates TPL
  - TPL indicator was checked or information was entered in the TPL section of the claim form
  - No EOB with Reason and Remark codes were attached

Eligibility

- Client ID missing or invalid
- Client not eligible for date of service
- Client is not eligible for Medicaid
- Client not eligible for service type
  - MHSP only
  - HMK/CHIP only

Non-Covered Service

- Adaptive items for daily living
- Environmental control items
- Building modifications
- Automobile modifications
- Convenience/comfort items
- Disposable incontinence wipes
- Sexual aids or devices
- Personal care items
- Personal computers
- Alarms/alert items
- Institutional items
- Exercise/therapeutic items
- Educational items

Non-Covered Service continued

- Items/services provided to a client in a nursing facility setting (see the *Nursing Facility Services* manual for details)
- Furniture associated with the use of a seat lift mechanism.
- Scales (covered if monitoring weight is part of any congestive heart failure (CHF) treatment regimen).
- Backup equipment
- Items included in the nursing home per diem

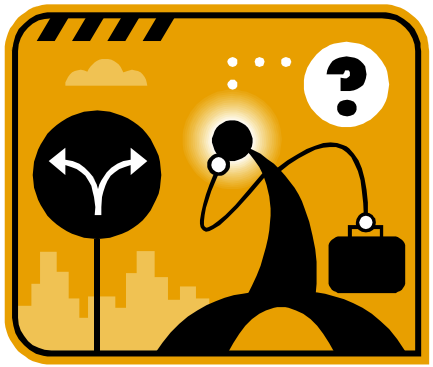
Medical Necessity

- Certificate of Medical Necessity is not on file
- Medicare denied for Medical Necessity
- Supporting documentation was not presented

Limits
(capped, routine, inexpensive)

- Rentals
  - 13 months of rental reimbursement
  - Additional or related items are not reimbursable during this 13-month period
  - Change in supplier during a 13-month period will not result in a new 13-month period or new purchase price limit

Questions?



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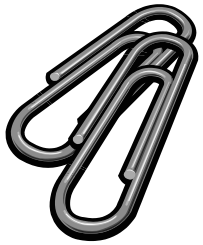
Attachments



Attachments

- Claim Specific
  - TPL-denial / total allowed to deductible.
  - Medicare EOMB for Part B or Part C.
- Non-Claim Specific
  - Blanket Denial Form

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Paperwork Attachment Cover Sheet

Paperwork Attachment Control Number: _____

Date of Service: _____

Billing NPI/API: _____

Client ID Number: _____

Type of Attachment: _____

Instructions:
This form is used as a cover sheet for attachments to electronic and paper Montana Health Care Programs (Medicaid; Mental Health Services Plan; Healthy Montana Kids; Indian Health Services Program) claims sent to ACS.

The *Paperwork Attachment Control Number* must be the same number as the *attachment control number* on the corresponding electronic claim. This number should consist of the provider's NPI/API, the client's ID number and the date of service (mmddyyyy), each separated by a dash (NPI: 9999999999-99999999-99999999/Atypical Provider ID: 9999999-99999999-99999999).

This form may be copied or downloaded from the Provider website (http://medicaidprovider.hhs.mt.gov/). If you have questions about which paper attachments are necessary for a claim to process, please call ACS Provider Relations at (406) 442-1837 or (800) 624-3958.

Completed forms can be mailed or faxed to: ACS
P.O. Box 8000
Helena, MT 59604
Fax: 1-406-442-4402

PWK
(Paperwork)

- Coversheet
  - Client ID required
  - NPI / Provider number
  - Date of service

- Cover sheet and attachment are imaged and stored in the document repository for referral.

Claims Processing and PWK

- Electronic claims
  - Must have the PWK indicator in the proper loop (2300) and segment or it will not be referenced.

    Example

    PWK✲OB✲BM✲✲✲AC✲DMN0012~
- Paper claims
  - Any edit posting on a claim requiring additional documentation to work results in a search for paperwork.

Special Processing PWK

- Some procedure codes that require a description
  - E1399
  - B9998
  - K0108

Questions?

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Medicare Crossovers

Medicare Crossovers

- Claims crossover automatic from COBC-GHI
- What does crossover
  - Institutional Claims
  - Professional Claims

Claims That Do Not Crossover

- Options
  - Bill electronically with appropriate Medicare qualifiers and data included in transaction
  - Bill electronically with PWK indicator and send Medicare EOB as paperwork attachment
  - Bill on paper forms

Paper Billing

- Bill on paper claim forms
  - Professional
    - Do not enter Medicare information on 1500
      - No Medicare paid amount in field 29
    - Attach a copy of the Medicare EOB for all paper claims submitted
      - Include reason and remark code description for all Medicare denials

Common Issues Resulting in Denials

- Client has Medicare on file and no Medicare information is present on claim
- Medicare denied service as not medically necessary
- Medicare EOB and claim do not match
  - Check
    - Client, date of service, billed amount, and procedure code
- Medicare denial reasons are not attached

Common Issues Resulting in Denials

- Medicare denied as a duplicate
- Medicare denied for a billing error
- Medicare denied for timely filing
- Medicare denied for service not paid separately
- Medicare denied because service paid by another payer

MONTANA
Department of Public Health & Human Services

Third Party Liability

TPL Responsibilities

- Insurance verification
- Assist with problem claims
- Retro Medicare
- Carrier Billing
- Provider checks/refunds
- Credit balance
- Trauma investigations

Services to You

- Pay and Chase
  - 90 Day Rule — Providers can request that Montana Health Care Programs process the claim and subsequently bill the other payer.
  - Specific circumstances result in automatic pay and chase.
    - Some prenatal and pediatric codes

Blanket Denial

- Include documentation that the client's other insurance never pays for a particular service.
- Requests are available on the web or from TPL. Complete and return requests to TPL.

  Fax to 406-442-0357.
- In return you will receive the blanket denial along with a tracking reference number to be used for billing.

REQUEST FOR BLANKET DENIAL LETTER
ACS – State of Montana Medicaid

Effective Date Requested _____ Provider / NPI _____

Client Name _____

Medicaid ID Number _____

Name of Insurance Company on File _____

Procedure Codes Requested

1. _____
2. _____
3. _____
4. _____
5. _____

Requesting Agency _____

Fax Number _____

Contact Person _____

Contact Phone Number _____

Number of Pages that Follow Request _____

Please fax all requests to (406) 442-0357.

Request must include an EOB stating the services are not covered.

How to Bill Using a Blanket Denial

- ACS staff work TPL edits that post for which a blanket denial has been created.
  - **Electronic claims**: include *pwk* indicator and tracking number.
  - **Paper Claims**: send the claim and a copy of the blanket denial
- Blanket denials are valid for two years from date on the request. Renewals must be requested and are not automatic.

Common Problems

- No TPL amount on the claim
  - If you have information TPL has termed, please call Provider Relations @ 1-800-624-3958
- Medicare information is put in as a TPL amount
- No paperwork attachments

What Should I Send to TPL?

- Problem TPL claims
- 90-day pay and chase claims
- Verification requests from TPL
- Blanket denials
- Refund checks
  - Note if it's for credit balance

Thank you for attending!

Questions?